A. Uh-huh.

Q. Did this pathology report give you any additional insight into Mr. Reed's cancer that you didn't already have?

A. No. It just confirmed that he did have a rectal cancer. Just confirmed everything we already knew.

Q. In a patient with Mr. Reed's diagnosis, do you provide palliative chemotherapy immediately after they've had the colonoscopy and colostomy, or is there some time that they need to heal first?

MR. BISWELL: Do you understand the question?

THE WITNESS: Yes.

A. Not from the colonoscopy or colostomy, these are relatively minor surgical procedure, or the port. We -- again, if we have the luxury of waiting and we have somebody with early cancer, good health, you want to wait a couple of weeks, you wait, but when you are in a race against time with very aggressive cancer, we don't have to wait after these procedure.

BY MS. KINKADE:

Q. Okay. So after his surgery with Dr. Rosett, is there a reason why Mr. Reed didn't receive

chemotherapy while inpatient at Richland?

A. Richland do not have an in-hospital inpatient oncology service.

Q. If Mr. Reed was to be transferred to Carle, does Carle Hospital have that oncology service?

A. They do, but I don't know then if they would have decided that he was in a shape and ready to start the treatment, but probably, maybe. Some of the treatment -- I have to go back and correct myself.

Some of the treatment I was planning to give him, specifically the Avastin, is something we don't give immediately after any procedure. We wait at least for two weeks. But the other chemo could have been given sooner.

Q. And the decision to transfer him from Richland to Carle, do you know who makes that decision?

A. The surgeons -- the surgical team.

Q. Okay. So Dr. Rosett's team?

A. Yes. There was Dr. Reid at that time and Dr. Silverman and the admitting physician, admitting internal medicine doctors, I think Dr. Garrett, but there was a whole team taking care of him directly.

Q. And at some point --

MR. WEIL: Object to form to the last

question. Go ahead.

BY MS. KINKADE:

Q. At some point, he was transferred to Carle Hospital; is that right?

A. After the last time I saw him, October 17, things went like out of control, and he got very sick with so many different problems and complications and directly and indirectly from the cancer, and there was a lot of intervention done, surgical, nonsurgical treatment, that I cannot speak of directly, but, you know, the timing and the sequencing, what would happen, I was just kept in the loop, and I had a general idea what was going on, and I would give my reco -- verbal recommendation for the doctor what to do, but everything I would answer about this period, it would see -- be from, you know, verbal communication, record I read, because I wasn't directly involved with him at that time, but to go back and answer your question, yes, he was transferred to Carle at some point after that, probably 10 days or 12 days later.

Q. And do you have privileges at Carle?

A. Champaign? No.

Q. So his cancer was being overseen by oncologists at Carle when he was admitted there?

A. Probably, yes.
Q. Did they consult with you at all?
A. I don't remember talking directly to a medical oncologist there. I cannot say 100 percent sure or not, but I don't remember. Usually they do. I know personally some of the oncologists there, so if it happens one of my patient happen to be at Carle, especially if the patient is -- has complicated, you know, case, they do call, but I cannot remember for sure about Mr. Reed if they talked to me at all or not.
Q. So when Mr. Reed is inpatient at Carle Hospital, the decision to initiate chemotherapy rests with the oncologists there that are overseeing his care?
MR. WEIL: Object --
A. Correct.
MR. WEIL: -- to form.
BY MS. KINKADE:
Q. Do you know when Mr. Reed started having some complications with his kidneys?
A. I don't recall exactly when. I learned about it later, but probably around the time he was in the hospital at Olney and when all these procedure were being done, and it doesn't take long for this problem

10/29/2018. So I saw him. I kind of kept updating myself what's going on, biopsy, for instance, on metastatic cancer. He has -- also has multiple liver mass. I don't --

THE COURT REPORTER: I can't understand you. I'm sorry.

THE WITNESS: I'm just reading quickly some of my notes on that consult, just skipping through lines, just trying to remind myself what this document about. Okay. I'm sorry. I'll try not to say anything unless meaningful.

BY MS. KINKADE:

Q. Okay. So you saw Mr. Reed on October 29th, 2018 at Richland?

A. I'm sorry. We have third -- the other page, the page after that, because that finished the sentence just started? Yes.

Q. Okay. And informed -- or you talked to him several times about his overall prognosis is poor?

A. Yes.

Q. What does that mean?

A. That mean he has relatively very bad cancer at a bad stage that's incurable, and not only that. When say poor means unlikely to do well with the

current knowledge we have at that time and current available treatment at that time. I'm just conveying to him that I wasn't very optimistic at that time of any good outcome.

Q. And you said the treatment is palliative and may depend on the cancer molecular profile?

A. Yes, because this is where the molecular profile may come in -- in play. I was hoping maybe we would find something that some of the newer treatment may actually make a difference, but in general, that treatment is not very promising.

Q. And then I'm showing you page 132. It's a note from I believe Dr. Rosett that there is a CT scan showing possible cancer at the T7 in his spinal column?

A. Yes. That -- that was note from Dr. Reid, one of the other surgeons.

Q. Okay. At this time, when he's at Richland and you see him, could you have ordered chemotherapy or systemic treatment?

MR. BISWELL: Object.

MR. WEIL: Object to form.

MR. BISWELL: You may answer it.

A. Again, number one, Richland Memorial Hospital, they do not have an inpatient chemotherapy

setting at all. To give chemotherapy in a hospital, they have to have all setting. They have to have a special pharmacy, trained pharmacist, special facility, and good -- to mix chemo, they need to have special trained chemo nurses, and at Richland, they don't have it. So even if I have a candidate patient that can receive chemo in the hospital, patient cannot have that done. He will need to be transferred to a hospital where they have an inpatient ability to give chemo.

The chemo I am giving in Olney is an outpatient chemo. It's not inpatient chemo. We bring our pharmacy, we bring our drugs, we bring our nurses, we bring our staff. Everything is ours. We don't use -- we don't have any assistant in the hospital. We just use the hospital building at the location for the outpatient. That's number one.

Number two, even though sometimes we try to push patient to take chemo when their prognosis is poor and waiting is not in their best interest and unlikely to do better, but you still have to have a minimal decent performance status for a patient to take chemotherapy, and in general, any patient who is in the hospital because he's sick, because he cannot make it on his own outside the hospital, he is in the hospital as an

inpatient for health reason, this patient in general is not a candidate for chemotherapy. He's too sick to take chemotherapy, and that's why most of our chemotherapy is -- not almost -- exclusively as an outpatient, because patient needs to be healthy enough to be able to make it to outpatient clinic. That's kind of a way of telling about the performance status we're talking about. If somebody too sick to make it on his own at home, in general he's too sick to take any chemo. The chemo is more likely going to cause more damage than help.

BY MS. KINKADE:

Q. Okay. So --

A. Actually I mentioned in my note that I was just hoping for him to get better enough to be discharged so we can start the chemo as an outpatient, but that was before he started having all these other complications.

Q. So it looks like you next saw him on November 14th, 2018. Do you have that report, or I can show you the paper copy that's page 183?

A. So I know that he had a lot of issues for a couple of months, and then eventually he made it out and he came to see me, and I know it was by the end of

BY MS. KINKADE:

Q. Okay. And were you consulted about his condition when he was discharged on November 3rd?

A. I do not remember. Probably the surgeon told me like verbally. We used to talk, you know, all the time about all patients, so probably they did. I do not remember.

Q. And do you know if Mr. Reed was in a condition to start receiving chemotherapy on November 3rd, 2018?

MR. WEIL: Object to form.

A. I cannot remember.

BY MS. KINKADE:

Q. Okay. In this November 14th, 2018 note, you said in the middle of that fourth paragraph: I was hoping actually that he would have been started on chemotherapy when he was at Carle Clinic as an outpatient, but they did not.

A. At that time, I was like hoping he would start on treatment as soon as possible and was getting out quickly. He was deteriorating. Situation was very difficult. He had to go through a lot. And many time would be in a condition would not be able to take chemo, and then he would get better, and would be a

good person to take the -- take pill then, but then he would lose it very quickly. It was just going up and down very quickly, very rapidly so much going on. It's very hard to keep track at that specific moment of time.

I -- over here, just reading my notes, I remember that there was a period in the middle of November where he was doing a little bit better. It would have been probably a good time to take chemo, but he was still not good enough to be discharged, and there was no way of taking chemo as an inpatient.

Q. At Carle?

A. At Carle. No. At Richland. This was at Richland. I'm talking at Richland.

Q. Okay.

A. At Carle, I don't know anything that happened in Carle.

Q. Okay. So your note here when you said that you were hoping that Carle Clinic would have started chemotherapy, is that a criticism of the physicians at Carle Clinic or is that just a byproduct of his instability and his condition?

MR. WEIL: Object to form.

A. That was a general statement that he was

just doing too bad that he couldn't take it for whatever reason was. I wasn't criticizing Carle. I didn't know how sick or well he was at Carle and if he was in shape to take treatment or not.

BY MS. KINKADE:

Q. Okay.

A. I was just like feeling that we're losing this opportunity and we were probably losing him and I was just feeling bad probably.

Q. Okay. And then when you saw him on November 14th, he had been re-admitted into Richland with some new complications, including that he was -- had no feeling in his lower extremities; is that right?

A. Apparently, yes.

Q. For your assessment and plan number one, you said: At this point, he has to get better, and I hope his obstructive symptoms resolve.

Did Mr. Reed's complications get better from this point forward?

A. I don't think so.

Q. But if -- okay.

And then number two, you said you're afraid his overall prognosis is extremely poor, his chance of survival is getting less and less.

Now, I want to ask you what you meant by that when you said his chance of survival is getting less and less. Before, you testified that his condition was incurable?

A. Yes.

Q. Okay. How -- how would a person with an incurable disease have a survival chance?

MR. WEIL: Object to form, asked and answered.

A. Well, language wise, this is a wrong word, but I didn't mean his chance of survival meaning a chance of curing his disease. I meant his chance of having any meaningful remission was less and less.

BY MS. KINKADE:

Q. Okay. Okay. That makes sense. You said: We still have a window of opportunity to start him on chemotherapy, hoping to reverse the process and get his cancer under control, shrink some of his lymph nodes, and then things can get better.

Is that still the palliative therapy that we were talking about before?

A. Yes. This is the whole goal of the palliative therapy, is that for him specifically, you would assume that this is a young, healthy patient that

-- otherwise, aside from his cancer or all the complication from his cancer, you would assume he -- he was a healthy person. So you would assume every problem he has is directly from the cancer or complication directly or indirectly, and this is where we feel like urge, probably we should start treatment as soon as possible, because even though he was not in his best shape, maybe given a treatment may give him a hope, give him a hope that stop the process, reverse it, and then everything may get better, including the very bad symptoms he's having. So this is a palliative, but then your focus may actually work if we can just initiate some treatment by kind of stopping the disease for just few days and then maybe reverse it, maybe all of his other problems may get better little by little, but he had obstruction in his bowels, he had obstruction of his kidneys, he have compression fraction -- fracture and spinal cord compression in his back. He had all these things. So if you give a treatment, you don't have to cure the disease. If you can shrink his lymph nodes by 20 percent, then maybe the obstructive uropathy will be resolved and the urine will start flowing and you will take out his nephrostomy tube. If you can shrink the tumor mass by

20 percent, maybe he will start passing stools and then get rid of the ostomy, and then maybe that would give him better nutrition and then maybe he would be stronger, then maybe he would start bouncing back, and then he would be able to take more chemo, and this is what we go for. This is the palliative treatment. It's palliative, not curing the cancer, but controlling it and improving the quality of life, and some patients with -- if the cancer is sensitive to treatment and responsive to treatment, they get really durable lives, good control over the cancer for months, sometimes you hope for years, even if you don't cure it, but you cannot do that unless you start some treatment to start reversing the process, but the sicker the patient is, the more advanced the cancer is, the harder it is to get into this window of opportunity. It's a window of opportunity I'm talking about, and he was losing this window of opportunity.

Q. Okay. It sounds like you said the first step for this reversal of his complications would be his cancer would have to be responsive to chemotherapy, right?

A. Correct.

Q. And not all cancer is responsive to

chemotherapy?

A. No.

Q. Okay. And then if his cancer was responsive to chemotherapy, it could reduce some of his symptoms and potentially give him better quality of life and live a longer life span?

A. Correct.

Q. Okay. And at this point, when you're writing this note, you don't have his molecular profile, which would give you insight on whether his cancer was likely to be responsive to chemotherapy?

MR. WEIL: Object to form.

A. We know quite a bit of colon cancer in general. We know about other factors that may rule. And the molecular profile was eventually -- it will add more insight, but it wasn't the only thing.

BY MS. KINKADE:

Q. Right. But you didn't have the benefit of knowing the results of the molecular profile when you're coming up with this assessment and plan?

A. It wasn't available to me at that time.

Q. And then you said that window of time is a couple weeks?

A. Apparently, --

MR. WEIL: Object to form.

A. -- from my experience and assessment at that time, probably that how I felt. That could have been wrong, but apparently that what I felt at that time.

BY MS. KINKADE:

Q. And Mr. Reed remains inpatient for two to three weeks after this note; is that right?

A. Well, you have the records. It's probably very clearly stated in the records, so --

Q. And so the person who is making the decision to start this chemotherapy would have been either Dr. Rosett's team to get him transferred or the Carle team who would initiate the chemotherapy; is that right?

MR. WEIL: Object. Object to form.

A. I don't really know who was the person who's responsible at that time. There was so much going on that I cannot remember details, what happened then and if it was before his radiation or not. So many things were going on at the same time.

But when I say in my assessment that I think we have very short window of opportunity to treat him, that doesn't necessarily mean, Okay, this is the time

we have to make a definite effort to start now. It's just like a general assessment thing that he's not doing very well and we have short window of opportunity. It doesn't mean he was ready to take treatment at that time because there was so much going on.

BY MS. KINKADE:

Q. Okay.

A. Maybe it wasn't for a week or so until after he heals and -- or then I wasn't quite sure what they were doing day-to-day at that time in the hospital or what kind of care, if he was ready to be transferred or not, I'm not sure.

Q. Okay. But ultimately those treatment decisions would have been the providers at the facility he was inpatient at?

MR. WEIL: Object to form.

A. Yes. In general, the decision about what to do, whether to transfer patients or not, is the responsibility of people taking care of him at the facility, but, again, there was no inpatient oncology service at Carle.

BY MS. KINKADE:

Q. You mean at Richland?

A. At Carle Richland. Mostly I'm saying about Carle. Just to -- to be clear, Richland now became Carle, so it's called Carle Richland. That's why -- at that time, it wasn't. It was independent, Richland.

Q. Okay.

A. But, yes, Carle Richland, at Richland.

Q. And so when you say the window is the next couple weeks, it sounds to me like you're saying in a couple of weeks, his condition is not likely to be any better?

A. My feeling --

MR. WEIL: Object to form.

A. -- then was probably it was then or never.

BY MS. KINKADE:

Q. Okay. You mentioned you were unsure when he started radiation, palliative radiation. Why is that significant to you in the determination of starting palliative chemotherapy?

MR. WEIL: Object to form.

A. I wouldn't say it was like directly related, but in addition to all the problem that he had, having the compression fracture and spinal cord compression and becoming permanently paralyzed, that

probably, you know, usually would add a big load to the whole situation and would make any likelihood of being able -- any likelihood of this wishful thinking I was thinking, trying to reverse the process, would make it extremely much less likely then, because that added big, heavy health issues and problem on the patient, would make him less likely to benefit from the treatment and less likely to be able to tolerate much treatment, and hoping to reverse the process to give him a decent quality of life, which is the main goal of palliative therapy, would kind of disappear when somebody is already permanently paralyzed.

BY MS. KINKADE:

Q. So, you know, if -- if the treaters making the decision to initiate chemotherapy considered that he was getting radiation would make the chemo treat -- would make his condition worse, that would be an appropriate consideration?

MR. BISWELL: Can you rephrase that? I don't think I -- as asked, it's like a state of a mind of somebody else question, so --

BY MS. KINKADE:

Q. Well, is it sound medical judgment for a provider to delay palliative chemotherapy for

palliative radiation?

A. For somebody --

MR. WEIL: Object to form.

A. -- someone with acute spinal cord compression who needs --

THE COURT REPORTER: Who needs what? I'm sorry.

THE WITNESS: I'm sorry. Was that --

MR. BISWELL: The court reporter didn't --

THE COURT REPORTER: You said who needs and I didn't hear the words after that. I'm sorry.

A. For someone with acute spinal cord compression who needs palliative radiation therapy, we would not start chemotherapy at the same time. Number one, we don't give chemotherapy at the same time with radiation therapy that's given for palliative purpose, because it's short and quick.

Number two, it's far more important to deal with the spinal cord compression. Spinal cord compression constitutes one of the very few oncological emergencies, and it takes priority over everything else because it leads to permanent paralysis and damage, and once you find out about it, you need to initiate treatment immediately with either immediate

neurosurgery or radiation therapy, and the role of chemotherapy in his cancer is -- becomes less priority for sure.

BY MS. KINKADE:

Q. And just to be clear, during this time when you're writing the November 14th note, you're not waiting on something from Wexford to start any sort of chemotherapy treatment for Mr. Reed?

MR. WEIL: Object to form.

A. Wexford is what?

BY MS. KINKADE:

Q. I'll --

A. The medical team at the facility?

Q. Right.

A. No.

Q. Okay. So you're -- at some point, you received the molecular profile on Mr. Reed's cancer?

A. Yes.

Q. And what did that tell you about his cancer?

A. It was consistent with a profile that we usually see with a very aggressive cancer with a worst overall prognosis than other average colon cancer and kind of more resistant to traditional chemotherapy.

Q. What does that mean for his prognosis?

A. This is not specifically for prognosis, but this would tell me that there is a category of medications that we may use for metastatic colorectal cancer. It's called EGFR inhibitors. It's a category of cancer treatment that might be one of the good choices for patient with colorectal cancer down the road like as a second line treatment or a third line treatment, will help us control the disease longer.

This category of medications does not work in patients with NRAS mutation. So he would lose his possibility in the future if it -- if it came to that point.

Q. Okay. You told -- I'm looking at the December 19th, 2018 appointment with Mr. Reed. After you received the molecular profile, pages 35 and 36 of the Bates records, you told Mr. Reed the options for treatment are supportive care only and comfort care versus palliative chemotherapy?

A. Yes.

Q. What does that mean?

A. Exactly what it says. The options are doing nothing, just supportive or comfort care, which what we talk about before, just make his -- make him

comfortable, treat his pain, or palliative chemotherapy.

Q. And is part of that --

MR. WEIL: Jaclyn, I'm sorry. I was talking. I was on mute. Can you tell me what page you're on?

MS. KINKADE: 35 and 36.

MR. WEIL: 35?

MS. KINKADE: 35 and 36. Yeah.

MR. WEIL: Thank you.

BY MS. KINKADE:

Q. And was this treatment options informed by the molecular profile?

A. No. This is -- this is the same treatment we talk about all along, but at this point, he was doing much, much poorly than the first or second or third or fourth time I saw him, so I made it clear that he has the option of not doing anything and just get comfort care, because at that time, I had very little hope of any really did anything, there was any hope of -- that the palliative chemo would work, so I wanted to make sure he understand that he has the option of doing nothing, just comfort care, and that doesn't have anything to do with the molecular profile. He was just

doing so poorly, and, yes, because the molecular profile was bad, but it wasn't directly related, because I wasn't planning to treat him differently than I originally planned to.

Q. Okay. And then you also have in your notes that from the molecular profile, it says MSI-stable?

A. Correct.

Q. What's that mean?

A. It's just one of the characteristic of the cancer, also make us lose the chance to give him a different type of treatment that would have been a good option. For patient with his poor performance status, there's about 10 percent of patient with colon cancer has a -- has a 4, 5 called MSI-I or MSI-unstable. This kind of patient may -- actually treated with immunotherapy, that may work, which is more incurable than people may be more effective. So if he had the MSI-unstable or MSI kind disease, then maybe a different option would have been given, less toxic, maybe -- maybe more promising, but, unfortunately, he didn't have it, so that was not an option. I just wanted to mention it, that I tested it and it wasn't an option.

Q. You say in your note that his disease is high -- very high risk and resistant to treatment, with extremely poor prognosis, especially with the BRAF mutation?

A. Correct.

Q. And that the presence of the NRAS mutation also makes it less likely to respond to treatment with EGFR inhibitor?

A. Correct. That what I just explained.

Q. His response to therapy in general is very limited and his life expectancy is very short?

A. That what I said.

Q. You said his treatment options are only palliative. That may prolong his life for a few months, but with significant toxicity?

A. Yes.

Q. Mr. Reed did want to move forward with the chemotherapy palliatively?

A. Yes.

Q. And this is the first time that you ordered a chemotherapy medication for Mr. Reed to be treated on?

A. Yes.

MR. WEIL: Object to form.

BY MS. KINKADE:

Q. And you ordered it to be initiated in two weeks?

A. Yes.

Q. You noted that there was some ulcers that Mr. Reed had developed while he was hospitalized?

A. Yes. Pressure sores, decubitus ulcers.

Q. And you didn't have any recommendations for a change in that treatment?

A. We didn't have many other choices.

MR. BISWELL: What treatment? Can you be more specific in that question? Treatment for what? The decubitus ulcers?

MS. KINKADE: Yes.

MR. BISWELL: Can you clarify that?

MS. KINKADE: Yes. Yes.

A. Okay. The treatment for decubitus ulcer?

BY MS. KINKADE:

Q. Let me rephrase the question. So you had given orders for chemotherapy. Shifting gears to the ulcers, you didn't have any recommendations for a change in the -- in the care that was already in place for Mr. Reed's ulcers?

MR. WEIL: Object to form.

A. I was not involved in the care of his decubitus ulcers.

BY MS. KINKADE:

Q. So is it just informative in your report?

A. Yes.

Q. And then you -- on January 2nd of '19, you initiated palliative chemotherapy with Mr. Reed?

A. Correct.

Q. And he signed a consent to that treatment at that time?

A. That's a routine we do.

MS. KINKADE: Is this a good time to take a few minute break?

MR. BISWELL: Yeah. How much more do you have?

MS. KINKADE: Not very much. I just want to get organized.

MR. BISWELL: Sure. Maybe let's keep the break five minutes.

THE WITNESS: Five minutes, because we have to finish by 4:00.

MS. KINKADE: Okay. I'm almost done. Okay. We'll take a five-minute break.

MR. WEIL: Okay.

Q. Okay.
A. -- related to his cancer.
Q. And those records that you would have reviewed from Lawrence Correctional Center, would those have been the records that are saved in your chart?
MR. WEIL: Object to form.
A. How much would that be saved or not, I'm not quite sure, because we move from paper charts to electronic medical records, and the nurses would take it and try to put in some of this information into the forwarded medical records, and then they go back to the discharge, to the discharge office, and where they get them next, I follow them, and sometimes we make copies. I'm not quite sure how much we keep is in our records. I usually give it back to the patient to take to the -- to the window where they make their follow-up appointment, and the staff take care of the record, and they keep whatever they were instructed to keep or scan whatever they were instructed to scan.
Q. And we've looked at your -- your appointments with Mr. Reed and your recommendations. None of those recommendations were denied by any of the prison staff for Wexford or Dr. Shah, Dr. Ritz or Dr. Ahmed to your knowledge?

MR. WEIL: Object to form.

A. I really don't think so.

MS. KINKADE: That's all I have.

MR. HILL: I don't have any questions. Thank you.

MR. WEIL: That's it?

MR. BISWELL: Yep.

MR. WEIL: Okay.

CROSS-EXAMINATION

BY MR. WEIL:

Q. Dr. Saba, thank you for sitting down with us today. My name is Steve Weil. I am -- I represent the Estate of Mr. Reed in this case. I want to direct you first to page 14 of the large document you have, so Bates page 14.

My computer is now not cooperating with me, but I'll get there.

MR. WEIL: I'll note that the time I have is 3:35 p.m.

BY MR. WEIL:

Q. You recall testifying that this document -- it reflects an appointment that you had with Mr. Reed on September 12th, 2018; is that right?

A. Right. Correct.

Q. Okay. And you mentioned that it takes a while to get things done, and part of what you mentioned was approvals. What did you mean by that?

A. You have to pre-authorize CT scans nowadays. We used to want to do a CAT scan, you called the hospital, you scheduled a patient, you get it the same day or next day. Now, you have to send it to a pre-auth office, either ours or the facility, and authorize it by the payer first and then get it approved and get an authorization number and then get the scan.

If you want to refer patient for colonoscopy, you make the referral. They call the GI doctors or the surgeon. They give patient appointment whenever available. Takes some time to get the patients in, and then he's scheduled for the procedure whenever available. Working, getting down to the bottom of the problem with a cancer and getting the right diagnosis and the stage and everything in order to start treatment takes time, and it's taking longer and longer because the decision of getting things done is taken away from the hand of the doctor, treating physician, more and more, and too many parties involved.

Q. Are you referring to your experience with

obtaining care for prisoners?

A. Not specifically. For all our cancer patients.

Q. Was it a problem that you encountered in obtaining care for prisoners who you treated?

MS. KINKADE: Object to form and foundation.

MR. HILL: Join.

A. Not really, but there are certain protocols you need to follow, which I'm not always, you know, familiar with, and it varies from one time to another. Just like when we take care of like veteran patients, if you want to do things, you have to go through the Veteran office first.

Here, I don't think there's significant delay in the thing that we recommend, but it has to be -- it has to go through the facility office most of the time really, not always. I would say there hasn't been significant delay in the things that I requested or I order in my patient from the facility as far as cancer from -- from the correction facility itself, but once in a while, you may see a little bit of, you know, inconsistency here or there, and it varies really from the doctors who are there. I mean, throughout the

years, as I said, I've been getting patient from Lawrence Correction Facility for like 12, 13 years now, and there was a different time when you have less consistency in the care of speed of getting things done depending on the doctor there. Sometimes I know them, sometimes I don't, but I would notice some differences, but nothing major really. They usually would do whatever we request in reasonably timely fashion.

BY MR. WEIL:

Q. When you say lately, Doctor, what -- what -- what time period are you referring to would you estimate?

A. Depends what we order and what we want. Have to be more specific.

Q. Sure. By lately, do you mean in the last year, the last two years, the last three years, that -- that kind of thing?

A. The thing is I don't follow-up closely on the staff over there and how it changes, and I would see so many different names here and there that I do not recognize. I do not know exactly how it works, if there is one person there all the time or they take part -- you know, part-time here or there.

Q. Let me -- go ahead. I'm sorry, Doctor.

A. I know at sometime there was one physician there that was not like right on top of her game, and I wouldn't very happy with the way things were done, but -- but that's about it, and she left, and she wasn't involved in Mr. Lenn care, but what I'm saying, how fast things done, how fast they carry out orders may vary from one time to another, but I cannot say there is a pattern of delay or bureaucracy like with delayed cancer care over there.

Q. Why don't we turn real quickly to page 20, Doctor, and this -- this is from your October 3rd appointment with Mr. Reed. I want to refer to your assessment and plan. It says -- on number one, it says: I will make him a referral to see a local surgeon as soon as possible, and hopefully they will approve it through the correction center quickly.

Do you see that?

A. Yes.

Q. Did -- can you explain what you meant in that passage?

A. Again, when I see patient from -- referred to me from any facility, different likes than self-referral, we make recommendation and then they're carried on through that office.

A. Well, I mean, you asking this question. I said I wish they did, but I didn't mean that they made a terrible medical mistake. They didn't. I'm saying maybe that was the very small timing window for opportunity we had. Maybe it was worth it, maybe it was not. It was a small window of opportunity. I just wish he was in the shape to take it. I just wish he took it. Just wishful thinking.

BY MS. KINKADE:

Q. Okay. And then on November 5th of 2018, sitting here today, you don't know if Mr. Reed would have qualified for chemotherapy at that time?

A. No.

MR. WEIL: Object to form.

BY MS. KINKADE:

Q. And chemotherapy isn't going to change somebody's prognosis if their cancer is nonresponsive to chemotherapy?

MR. WEIL: Object to form.

A. No. It's not going to change prognosis. If the cancer is resistant to the chemo we're giving, chemo would end up hurting them.

BY MS. KINKADE:

Q. And then is -- significant weight loss, is